✓ To fill in and save this PDF, use Adobe Acrobat Reader XI or later.

Psychology Progress Report

If applicable, please select the Lock button before submitting the form.
Please note: once the Lock button has been selected, the form will no longer be editable.

Lock

INVOICE INFORMATION			
CLAIM NUMBER	DATE OF ACCIDENT (dd/mmm/yyyy)	DATE OF REPORT (dd/mmm/yyyy)	VENDOR NUMBER
INVOICE/REFERENCE NUMBER	PAYEE NAME		
PAYEE ADDRESS			
PAYEE ADDRESS			

CLAIMANT INFORMATION			
FIRST NAME	LAST NAME	DATE OF BIRTH (dd/mmm/yyyy)	PERSONAL HEALTH NUMBER (PHN)

PRACTITIONER INFORMATION		
FIRST NAME	LAST NAME	PRACTITIONER NUMBER

Assessment Date(s)

DATE (dd/mmm/yyyy)	DATE (if applicable) (dd/mmm/yyyy)	DATE (if applicable) (dd/mmm/yyyy)	DATE (if applicable) (dd/mmm/yyyy)

Work Status

	PRE-ACCIDENT EMPLOYMENT/TRAINING	PRE-ACCIDENT STATUS	CURRENT EMPLOYMENT/TRAINING	CURRENT STATUS
PRIMARY STATUS				
SECONDARY STATUS				
TERTIARY STATUS				

Comments

PROVIDE ADDITIONAL COMMENTS ON STATUS OF OCCUPATION, AS RELEVANT

Return to Work Planning

Only fill this section, "Return to Work Planning", if the client was gainfully employed on the date of the crash and is not currently working, or working for modified hours/duties.

1. WHAT IS THE CLIENT'S CURRENTLY RECOMMENDED RETURN TO WORK STATUS?

○ Full work status ○ Modified work ○ Not recommended to return to work in any capacity

IF MODIFIED WORK, SPECIFY WHAT MODIFICATION:

☐ Modified hours ☐ Modified duties

If the client is not recommended to return to work in any capacity, fill out Question 2

2. RECOMMENDATION(S) ON RETURN TO WORK

Chief Complaints

IDENTIFY CURRENT SYMPTOMS (include psychosocial, cognitive and physical symptoms as relevant):

COMMENT ON ANY CHANGES TO INTENSITY AND/OR SEVERITY OF SYMPTOMS:

Functional Status at the Time of the Accident

Identify if the following functional areas have been impacted by the accident

3. UNDERSTANDING AND COMMUNICATION (cognition)

○ Yes ○ No

IF YES, PROVIDE COMMENTS:

4. FUNCTIONAL MOBILITY (at home and in the community)

○ Yes ○ No

IF YES, PROVIDE COMMENTS:

5. SELF-CARE (e.g. hygiene, dressing, eating)

○ Yes ○ No

IF YES, PROVIDE COMMENTS:

6. SOCIAL INTERACTION

○ Yes ○ No

IF YES, PROVIDE COMMENTS:

7. PRODUCTIVITY AND LEISURE (e.g. domestic responsibilities, leisure, work, school)

○ Yes ○ No

IF YES, PROVIDE COMMENTS:

8. COMMUNITY INTEGRATION

○ Yes ○ No

IF YES, PROVIDE COMMENTS:

9. COMMENT ON ANY SIGNIFICANT CHANGES TO FUNCTIONAL STATUS SINCE LAST ASSESSMENT:

Current Observed Findings

Comment on client's presentation (as relevant to activities of daily living)

10. IS THE CLIENT ABLE TO ATTEND SESSIONS INDEPENDENTLY?

○ Yes ○ No

IF NO, WAS THE COMPANION REQUIRED FOR SUPPORT?

11. METHOD OF TRANSPORTATION USED TO ARRIVE TO SESSION

12. DID THE CLIENT USE AN ASSISTIVE DEVICE?

○ Yes ○ No

IF YES, PROVIDE COMMENTS:

13. WAS THE CLIENT APPROPRIATELY DRESSED AND GROOMED?

○ Yes ○ No

IF NO, PROVIDE COMMENTS:

14. WERE BEHAVIOURS SOCIALLY APPROPRIATE?

○ Yes ○ No

IF NO, PROVIDE COMMENTS:

15. WAS THERE AN OBSERVED LOSS OF TRAIN OF THOUGHT OR LAPSE(S) IN ATTENTION?

○ Yes ○ No

IF YES, PROVIDE COMMENTS:

16. DID THE CLIENT UNDERSTAND AND RESPOND APPROPRIATELY TO INSTRUCTIONS?

○ Yes ○ No

IF NO, PROVIDE COMMENTS:

17. WAS THERE EVIDENCE IN SPEECH DIFFICULTIES?

○ Yes ○ No

IF YES, PROVIDE COMMENTS:

18. SUMMARY OF CLIENT PRESENTATION

Suicide Risk

19. IDENTIFY CLIENT'S LEVEL OF SUICIDE RISK

○ Present ○ Denied

PROVIDE SAFETY PLAN AND COMMENTS, AS RELEVANT:

Psychological Assessment Methods Used

LIST AND PROVIDE FINDINGS FROM PSYCHOLOGICAL MEASURES USED (e.g. BDI, BAI, HADS, PCS), AS RELEVANT:

Working Diagnosis

Medications

IDENTIFY CURRENT MEDICATION REGIME, AS RELEVANT:

Updated Treatment Goals And Plans

IDENTIFY UPDATED CLIENT-CENTERED TREATMENT GOALS

TREATMENT GOAL 1

TREATMENT GOAL 2

TREATMENT GOAL 3

TREATMENT GOAL 4

TREATMENT GOAL 5

UPDATED TREATMENT PLAN

20. TREATMENT TARGET (return to work factor to be addressed):

21. BARRIERS TO RECOVERY:

22. RECOMMENDED INTERVENTION(S) (e.g. treatment, modality, strategies and anticipated treatment length):

23. ARE THERE OTHER FACTORS THAT MAY IMPACT THE PATIENT'S ABILITY TO RETURN TO PRE-ACCIDENT FUNCTIONING?

○ Yes ○ No

IF YES, PROVIDE COMMENTS:

Additional Comments

Communication Request

24. DO YOU WISH TO HAVE A PHONE CONSULT WITH THE CLAIM FILE HANDLER?

○ Yes ○ No

25. DO YOU WISH TO HAVE A PHONE CONSULT WITH OTHER CLINICIANS INVOLVED IN THIS CLIENT'S CARE?

○ Yes ○ No

IF YES, SPECIFY WHICH ONE(S), THE REASON, AND THE URGENCY:

☐ By checking this box, I certify that the information provided is true and correct to the best of my knowledge.

Select one of the following:

☐ I have obtained consent from the client to share all information related to the history, examination, assessment and management of the injury related to the motor vehicle accident with ICBC.

☐ This report is being provided pursuant to a request by ICBC under Section 28 or Section 28.1 of the *Insurance (Vehicle) Act*.

Personal information on this form is being collected under section 26 of the *Freedom of Information and Protection of Privacy Act (BC)* and section 28 or 28.1 of the *Insurance Vehicle Act (BC)* for the purpose of obtaining a health care report in order to manage the claim. Questions about the collection of this information may be directed to the claim representative, or call 604-661-2800 or contact the Privacy & Freedom of Information department at 151 Esplanade, North Vancouver, BC V7M 3H9.